IN THE MATTER OF THE APPLICATION REGARDING CONVERSION
OF PREMERA BLUE CROSS AND ITS AFFILIATES

Washington State Insurance Commissioner's Docket # G02-45

REPORT OF

Milliman USA

Premera Comparative Premium Rate Analysis

November 10, 2003

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PREMERA
Comparative Premium Rate Analysis

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PREMERA

Comparative Premium Rate Analysis

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Section 1: Executive Summary

Introduction

PREMERA, Premera Blue Cross, and certain of their affiliates (collectively, "Premera") filed a Form A[1] application with the Washington Office of the Insurance Commissioner ("OIC"). This Form A was also filed with the Alaska Division of Insurance and the Oregon Insurance Department. The purpose of this filing is to request approval for Premera Blue Cross ("PBC") and its non-profit affiliates to convert from Washington non-profit corporations to for-profit business corporations.

PBC engaged Milliman USA, Inc. ("Milliman") to evaluate the likely premium rate impact, if any, of the proposed conversion; this involves a critical analysis of each premium rate component, including expected changes as a result of the conversion. We have reviewed and are familiar with the Form A application.

Milliman USA is an independent consulting firm that began in Seattle in 1947. The firm is an internationally recognized leader in the actuarial consulting industry.

Approach

To evaluate whether PBC's premium rates are likely to change as the result of the proposed conversion, we reviewed the components of PBC's premium rate structure and assessed the probable impact of the conversion on these components. Our analysis involved a comparison of modeled margins and premium rates under two scenarios: Scenario 1 is the current Without Conversion environment, and Scenario 2 is the simulated With Conversion environment.

The following subsections describe the Premium Rate Components, Modeling Scenarios, and Comparative Premium Rate Analysis. Summaries of our findings and conclusions follow this information.

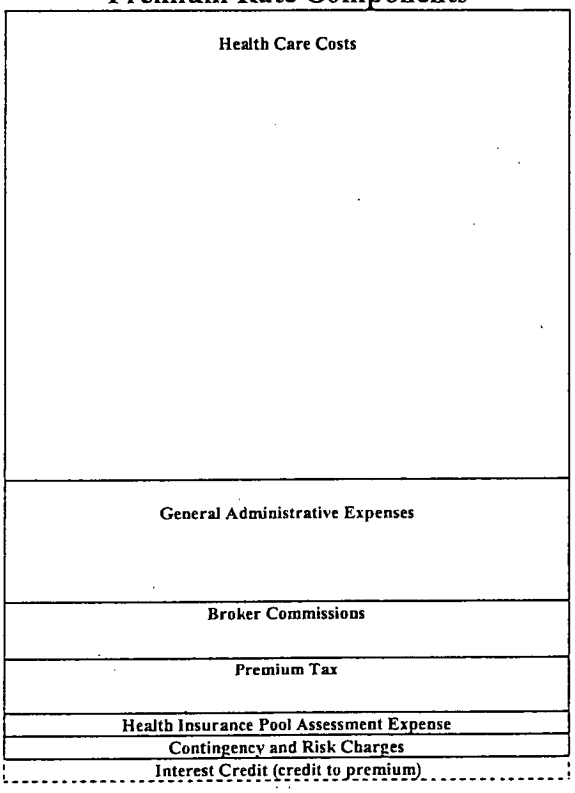
[1] Form A is entitled "Statement Regarding the Acquisition of Control of a Domestic Health Carrier and Domestic Insurer".

Section 1: Executive Summary (Continued)

Premium Rate Components

The primary components of PBC's premium rate structure are represented graphically below (but not to scale):

Premium Rate Components



The premium rate component illustration shown above is a general representation of components typically included in a health insurance premium, and their relative magnitude. This is an illustration only, and is not intended to reflect actual PBC amounts. Recognize that the interest credit component is actually a credit, which offsets expenses.

The premium rate components illustrated above are discussed in more detail in Section 3. However, we briefly describe each component below.

1. *Health Care Costs* – This is the dominant component in any health insurance premium rate and reflects the cost of health care services provided to insured members.
2. *General Administration Expenses* – Typically the second largest component, general administration expenses include the company's fixed and variable operating expenses.
3. *Broker Commission Expense* – This component reflects the commission expenses paid to brokers and/or consultants for selling and/or servicing insurance coverage to a member or insured group.

4. *Premium Tax* – This is a state tax imposed on health insurance premiums; the tax is directly payable to the state by each insurance company. In Washington, the current premium tax is equal to 2% of insurance premiums. The premium tax in Washington will not be affected by conversion, though a slight net increase is expected in Alaska.
5. *Health Insurance Pool Assessment Expense* – This is an assessment for the company's pro-rata subsidy of the state's High Risk Pool ("HRP"). The HRP offers health insurance coverage to individuals who are not eligible to purchase health insurance coverage directly through licensed insurance companies. The HRP premium rates are subsidized by an assessment on each company selling coverage in the state. The basis of the assessment reflects the relative business volume of each health insurance company doing business in the state.
6. *Interest Credit* – This component reflects the interest income earned on the portion of the premiums earmarked for claims that are incurred but not paid. There is generally a time gap between the date a medical service is performed and the date the associated claim is paid. PBC reduces premiums to reflect interest earned on this "float".
7. *Contingency and Risk Charges* ("C&R") – The C&R component of the premium rate provides for a) the risk of uncertainty of future events (contingency) and b) return on capital employed. C&R charges help build necessary surplus to weather unexpected contingencies that could otherwise result in financial impairment. C&R charges are also referred to as "margins". The accumulation of adequate surplus is critical to the ongoing viability of any health insurance entity.

Modeling Scenarios

In order to analyze the likely premium rate impact, if any, of the proposed conversion, we modeled the margins and resulting premium rates under the following two scenarios:

Scenario 1 ("Without Conversion") assumes that the conversion does not occur; this scenario reflects PBC's current environment, projected through 2008.

Scenario 2 ("With Conversion") assumes that PBC converts to a for-profit health insurance company. The Scenario 2 analysis also assumes a projection period through 2008.

Section 1: Executive Summary (Continued)

Our analysis of the Without Conversion scenario involved a 3-step process:

Step 1: Surplus Benchmark – We modeled the necessary and appropriate level of surplus required for PBC to remain viable after absorbing significant financial losses. Our analysis of appropriate surplus is based on the concept of Risk Based Capital ("RBC"). It is also based on observed financial results for PBC and similar companies where losses have occurred over a prolonged period.

Step 2: Margin Requirement - We calculated the average rating margin needed over the 5-year period ending in 2008 for PBC to achieve the surplus benchmark calculated in Step 1.

Step 3: Premium Rates – We then calculated the average premium rates for PBC's insured business during the 5-year period based on the margin calculated in Step 2.

Our analysis of the With Conversion scenario involved the same 3-step process:

Step 1: Surplus Benchmark - We used the same surplus benchmark from the Without Conversion Scenario.

Step 2: Margin Requirement – We calculated the average rating margin needed over the 5-year period ending in 2008 for PBC to achieve the surplus benchmark from Step 1. The projection assumptions used in this process include changes in rating components (e.g. Alaska premium tax) and investable assets that can reasonably be expected to result from the conversion.

Step 3: Premium Rates - We then calculated the average premium rates for PBC's insured business during the 5-year period based on the margin requirement from Step 2.

Comparative Premium Rate Analysis

The final step in our analysis was to compare the average premium rates calculated under the two scenarios. This comparison is summarized in the "Summary of Findings" and discussed in more detail in Section 4. The premium rates under both scenarios are roughly equivalent; rates from the With Conversion scenario are slightly lower. The lower rate levels in the With Conversion scenario are due to an increase in assets and investment income, which more than offsets the increase in Alaska premium tax. This results in a lower modeled margin than under the Without Conversion scenario.

Summary of Findings

Based on our analysis and a comparison of the results under the two scenarios, we find that:

1. The components of the premium rate structure (described above and discussed in more detail in Section 3 of this report) are not likely to vary significantly between the two scenarios.

2. Modeled premium rates over the next five years do not differ significantly between the two scenarios. The results of the premium rate comparisons are shown in the following table:

Comparison of Modeled PMPM[2] Premiums, With and Without Conversion

Scenario	Description	2004 PMPM	2005 PMPM	2006 PMPM	2007 PMPM	2008 PMPM
PROPRIETARY MATERIAL REDACTED						
	Difference (1)/(2)-1	0.5%	0.5%	0.5%	0.5%	0.5%

3. Rating margins included in current PBC premium rate projections are generally not sufficient to meaningfully increase PBC's surplus in relation to RBC benchmarks. In the absence of a conversion, margins would have to increase in order to accumulate a surplus level that would adequately guarantee coverage for the groups and members served by PBC. Plan management has focused on achieving adequate surplus during the past several years. However, due to market constraints and the need to invest in infrastructure, PBC has not been able to increase margins to the levels necessary to build adequate surplus.

[2] Referenced on a "per member per month" basis.

Conclusions [3]

1. Premium Rate Components – Other than a relatively small increase in Alaska premium tax, the conversion is unlikely to generate changes in the components of PBC's premium rate structure.
2. Premium Rates – PBC's conversion from a non-profit to for-profit health insurance company is not likely to result in any material impact on its premium rates.

[3] The conclusions offered in this report are based in part on discussions with, and information received from PBC, including the Form A filing, and supporting material, historical financial statements and recent PBC Small Group Rate Filings. While this information was reviewed for reasonableness and consistency, we did not attempt to audit the information or otherwise verify its accuracy. If the information on which we relied is inaccurate or incomplete, our conclusions may likewise be inaccurate or incomplete.

Note that premium rate levels illustrated in this report have been modeled in the aggregate. Such rates are not a substitute for actual, specific rates that will be developed for PBC, nor should they be deemed as a constraint on future premium rate development.

Section 2: Methodology

Limitations

This report has been prepared solely for use by PBC management, the Washington Office of the Insurance Commissioner, the Alaska Director of Insurance and the Oregon Department of Insurance and for use in any hearing regarding the Conversion. It should not be distributed in whole or part outside of this audience without Milliman's advance written permission, and then only after redaction of any proprietary or confidential information. The Executive Summary can be distributed as a separate document, after redaction of any proprietary and confidential information.

Summary of Methodology

PBC asked Milliman to evaluate the likely impact of conversion on premium rates.[4] PBC has already indicated that the conversion will not materially affect its target markets, product offerings, or related distribution channels and support services.

In order for any business to succeed over the long term, revenue must exceed expenses. As applied to health insurance, this principle means that premium income for insurance contracts must exceed expenses associated with those contracts. Our approach to analyzing whether PBC's premium rates are likely to change materially as the result of the proposed conversion involved reviewing the primary *components* of premium rates, then assessing the probable impact of conversion on these components.

The impact of conversion was modeled over a five year period using the following three-step process:

1. Simulate overall PBC premium rate levels assuming no change in the current non-profit status (Scenario 1, Without Conversion),
2. Simulate overall PBC premium rate levels after conversion to a for-profit health insurance company (Scenario 2, With Conversion), and
3. Compare simulated premium rates from the two scenarios.

[4] On October 27, 2003 PwC submitted a report entitled "Economic Impact Analysis of the Proposed Conversion of Premera Blue Cross for the State of Washington." PBC also asked Milliman to review and comment on certain aspects of that report. That review and comment is attached hereto as the Addendum to this report.

Section 2: Methodology (Continued)

Note that projections for the health insurance business are typically of fairly short duration. An abbreviated projection horizon is justified since the typical insurance contract runs for twelve months, and financial results are subject to external influences that are notoriously difficult to predict. Our modeling time horizon spanned the five year period from 2004 through 2008. Expected premium rate levels beyond 2008 are certainly relevant, but no projections were performed due to the added uncertainty involved. The starting point for our premium simulation was the Form A Filing projections (as resubmitted in March 2003) developed by PBC staff. The filing includes projections through 2007, and was developed based on actual results through 2002. Exhibit 1 summarizes selected Form A values relevant to our projection purposes.[5]

Since our modeling covers the five-year period beginning in 2004, it was necessary to extend the Form A 'baseline' projections to include calendar year 2008. To accomplish this goal, we continued the implied 2006-2007 trends for an additional year.

Our analysis of the components of PBC's premium rate structure is presented in Section 3. In Section 4, we examine margins and resulting premium rate levels under the two scenarios described above. Lastly, our conclusions are presented in Section 5.

[5] We have not reviewed the financial data in detail included in the Three Year Planning Tool recently presented to the PBC Board of Directors and provided to the OIC Staff. As such, we cannot determine the extent, if any, to which our findings and conclusions might change in light of these data.

Section 3: Discussion of Components in Premium Rate Structure and the Impact of Conversion

This section highlights elements of the premium rate structure, and the specific assumptions about various elements used in our projections. As previously noted, most assumptions were developed from the Form A filing.

Health Care Costs

This is the dominant component in any health insurance premium rate and reflects the cost of health care services provided to insured members. PBC has stated that if there is a conversion, it does not plan to make material changes to its operations and business plans. For example, care facilitation (e.g., disease management programs) and plan design will not be changed. PBC has therefore concluded that the conversion should not have an impact on health care costs in the states where it operates. After reviewing the Form A and based upon Milliman's knowledge and experience, we believe that PBC's assessment is reasonable.

Other Components of the Premium Rate Structure

The other primary components in the premium rate structure include:

1. General Administrative Expenses,
2. Broker Commission Expense,
3. Premium Tax,
4. Health Insurance Pool Assessment Expense,
5. Interest Credit, and
6. Contingency and Risk Charges.

Each of these rating components is discussed below:

General Administrative Expenses

General Administrative Expenses ("GAE"), which include both fixed and variable overhead expenses, represent the second largest component of PBC's premium rate structure (after health care costs). PBC expects membership growth over the projection period, which will favorably impact GAE per member, and we believe this assessment is reasonable. Note, however, that modeled premiums described below anticipate the same GAE for both scenarios.

Section 3: Discussion of Components in Premium Rate Structure and the Impact of Conversion (Continued)

GAE will be affected by the enrollment levels, which impact average per unit overhead expenses. Enrollment changes are driven by changes in factors such as:

a) Products offered,
b) Underwriting and marketing,
c) Sales activity,
d) Premium rate levels, and
e) Marketplace perception of the Company's financial strength.

PBC has stated that it does not intend to alter the existing product offerings as a result of the conversion, nor will it alter underwriting, marketing, or subscriber services. Therefore, administrative costs are not expected to change due to these factors.

PBC does expect that insurance company rating agencies will react favorably to increased surplus and financial flexibility expected to emerge as a result of a conversion and the stock offering. A favorable reaction, or an increase in the agency rating of the company, is likely to promote increased broker activity and positively impact enrollment. PBC expects that the increase in enrollment will result in the ability to spread administrative expenses over a greater number of policyholders, and consequently reduce per unit expenses.

Based on our review, we agree that it is reasonable to expect the conversion to produce a slightly positive effect on enrollment trends and, as a result, lower per unit GAE. Note again, however, that modeled enrollment levels are the same in both scenarios[6].

Broker Commission Expense

This component reflects the commission expenses paid to brokers and/or consultants for selling and/or servicing the insurance coverage to a member or insured group. PBC expects that current broker commission rates will not be affected as a result of the conversion, and this assessment seems reasonable.

Premium Tax

This is a state tax imposed on health insurance premiums; the tax is directly payable to the state by each insurance company. As explained below, the likely impact of conversion on premium tax varies somewhat by state.

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[6] Certain one-time expenses are expected to be incurred by PBC that are attributable to the activities surrounding and associated with the operational transition to a for-profit company. PBC has assumed that these expenses will be funded from current surplus, and there is no impact on premium rates due to the one-time nature of these expenses. This assessment seems reasonable.

Section 3: Discussion of Components in Premium Rate Structure and the Impact of Conversion (Continued)

Washington:

In Washington, the current premium tax is equal to 2% of insurance premiums. We understand that PBC's tax advisors expect the premium tax rate in Washington to remain unchanged following conversion.

Alaska:

In Alaska, PBC's tax advisors expect the applicable premium tax to increase in certain market segments. Currently, non-profit hospital and medical service corporations in Alaska are taxed on 6% of the amount of the gross premiums less claims; that is, the portion of the premium remaining to pay administrative expense and fund for contingencies. Additionally, foreign (e.g. not domiciled in the State of Alaska) insurers are subject to retaliatory fees. The net current average premium tax rate in Alaska is equivalent to approximately 2% of gross premium.

After conversion, the company will be subject to a different tax rate, which will result in a 2.7% tax on gross premiums for most business.

The impact of the increased Alaska premium tax is reflected in our projections for Scenario 2.

Health Insurance Pool Assessment Expense

This is an assessment for a company's pro-rata subsidy of the state's High Risk Pool ("HRP"). The HRP offers health insurance coverage to individuals who are not eligible to purchase health insurance coverage directly through licensed insurance companies. The HRP premium rates are subsidized by an assessment on each company selling coverage in the state. The basis of the assessment is reflective of the relative business volume of each health insurance company doing business in the state. The statutes and regulations in the respective states prescribe the assessment process and the calculation of the assessment amount.

Whether or not it converts, PBC will continue to be subject to state High Risk Pool ("HRP") assessments. PBC anticipates no change in the treatment of the assessments. We agree with this assessment.

Section 3: Discussion of Components in Premium Rate Structure and the Impact of Conversion (Continued)

Interest Credit

This component reflects the interest income earned on the portion of the premium earmarked for claims that are incurred but not paid. There is generally a time gap between the date a medical service is performed and the date the associated claim is paid. PBC reduces premiums to reflect interest earned on this "float". Such earnings are reflected in the interest credit component of the rate.

PBC does not expect the conversion to affect the interest credit, and this assessment seems reasonable.

Contingency and Risk Charges

The Contingency and Risk Charges ("C&R") component of the premium rate reflects the portion of total premium retained by the company to provide for a) the risk of uncertainty and b) return on capital employed.

C&R charges help build necessary surplus to weather unexpected contingencies that could otherwise result in financial impairment. C&R charges are also referred to as "margins". The accumulation of adequate surplus is critical to the ongoing viability of any health insurance entity.

Since all other components of the premium rate are expected to be largely unaffected by conversion, the key premium rate issue is whether the conversion is likely to affect C&R. Our modeling, as discussed in Section 4, calculates rating margins required to attain surplus benchmarks given certain assumptions. These rating margins are reasonable proxies for PBC's margin objectives under each scenario.

Section 4: Comparative Premium Rate Analysis

This section begins by describing a number of aspects of surplus adequacy related to the calculation of rating margins, then outlines the actual steps in our premium rate comparison work.

A. Aspects of Surplus Adequacy

1. Rationale for Surplus:

   Health insurers require surplus to withstand the financial fluctuations inherent in the health insurance business. Underwriting gain/loss results are the principal driver of fluctuation for most companies. Health carrier profit levels have exhibited a cyclical pattern for at least the past thirty years. During this period, underwriting results have tended to show multiple-year periods with gains, followed by multiple-year periods with losses. Intuitively, results for sequential years are not independent, since the 'duration' of underlying contracts often extends well into the future. Surplus is therefore necessary to withstand sustained periods of loss while honoring the promises made in offering health insurance protection to customers, and ensuring that promises and obligations to hospitals, physicians, and other providers can be met.

   Insurers also require surplus to fund growth, develop new products, build infrastructure, respond to new business opportunities, develop service capabilities, and meet other requirements of a viable business entity. Premium margins, investment income, and certain other income are the only ongoing sources of surplus for a non-profit health insurer.

2. Risk Based Capital:

   The formula for calculating Risk Based Capital ("RBC") for health insurance companies is relatively complex, and was developed by the American Academy of Actuaries and adopted by the National Association of Insurance Commissioners ("NAIC"). RBC benchmarks for most health insurers are primarily a function of two factors:

   a. *Underwriting Risk* – This reflects the risk of having inadequate premium rates in the future due to fluctuations in claim levels. The adequacy of premium rates depends on the amount of retained risk on a single individual, the type of coverage, the type of provider reimbursement utilized, the type of premium rate guarantees offered, and the amount of premium stabilization reserves held.

   b. *Business Risk* – This reflects the other risks of doing business, such as adequacy of administrative expenses, amount of assessments for guarantee funds and high-risk pools, and growth levels of the company.

3. Determination of Surplus Benchmark:

The simulated rating margin for both scenarios is tied directly to the question of adequate risk capital or surplus. The proper level of surplus is an issue open to some debate, but it is intuitively clear that there should be an acceptably small risk of falling below a minimum threshold. Judgment enters into the determination of "minimum surplus threshold" and "acceptable risk".

a. Minimum Surplus Threshold:

The minimum surplus threshold represents a minimum level, or floor, below which the viability of the company is in question. The NAIC has issued minimum surplus guidelines for health insurers, expressed as multiples of RBC. Two significant guidelines include:

1) Authorized Control Level ("ACL") – Defined as 50% of RBC. If a company's surplus falls below 100% of ACL, the Insurance Commissioner may require a corrective action plan, conduct an examination of the company, issue corrective action orders, and/or place the company under regulatory control if deemed to be in the best interests of the policyholders and creditors of the company.

2) Company Action Level ("CAL") – Defined as 200% of ACL or 100% of RBC. If surplus falls below this level, the insurer is required to submit a corrective action plan to the Insurance Commissioner that identifies the contributing conditions to the RBC level and provides a two-year financial projection with and without a corrective action.

A carrier can remain technically solvent with any positive surplus, but 100% of the ACL represents a practical minimum, as this level jeopardizes control of the company. In fact, many carriers view 200% of the ACL (i.e. CAL) as a minimum surplus threshold, since control begins to erode when surplus drops below this level. For purposes of our modeling, we have adopted 100% of ACL as the absolute minimum, recognizing that a higher minimum is clearly defensible.[7]

[7] A second guidepost to surplus adequacy comes from the Blue Cross and Blue Shield Association (BCBSA), which expects member Plans to maintain surplus at or above 375% of ACL. For comparative purposes, PBC's $311.7 million ending surplus for 2002 represented about 12.2% of 2002 annualized premium income, or 406% of ACL; thus, PBC's current surplus level just exceeds the BCBSA minimum target.

b. Acceptable Risk:

We analyzed historical adverse underwriting cycles in the health insurance industry to quantify the risk surrounding operating losses. Since 1980, PBC (or its predecessor entities) sustained three complete adverse underwriting cycles. Cumulative underwriting losses during these cycles ranged from 11.4% to 21.6%, where values are expressed in relation to average annual underwritten premium over the same period.

Since a sample of three cycles is clearly limited, we also considered adverse cycles for Blue Cross and Blue Shield Plans that are similar to PBC in terms of general size, geographical location, and/or operating environment. The process of defining the peer group entailed some compromise and judgment given limits on available data and the desire for a reasonable sample size. Exhibit 2 highlights results for the peer group, which includes PBC. As shown in this exhibit, the 75th percentile adverse cycle reflects a loss of approximately 14.5% of premium, while the 90th and 95th percentile counterparts were 19.4% and 24.6%, respectively.

c. Needed Level of Surplus:

We used the results of our evaluation of "minimum surplus thresholds" and historical underwriting results to model needed surplus under various scenarios, given PBC's Form A projections. The general question addressed was, "What starting level of surplus would be required in order to weather an adverse underwriting cycle at the nth percentile of severity?"

Table 1 summarizes results of this analysis for the 75th, 90th, and 95th percentiles, where 'weathering' is defined as ending the cycle with surplus level at or above 100% of simulated ACL.[8]

Table 1
Initial Surplus Required to Withstand Negative Underwriting Cycles

Desired Certainty/Safety Threshold	Starting Surplus ($million)	Starting Surplus (pct)	Starting ACL Multiple
75th Percentile	$572	19.8%	4.6
90th Percentile	$728	25.2%	5.8
95th Percentile	$894	30.9%	7.0

[8] For illustrative purposes, the adverse cycle is assumed to last through the 5-year projection period.

As indicated, the estimated starting surplus – expressed in relation to 2003 annualized underwritten premium - required to withstand an adverse underwriting cycle ranges from about 20% to 30%, depending on the safety threshold adopted. All benchmarks are well above PBC's current surplus level.[9]

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It is also important to note here that PBC's current average rating margin of [ ] as shown in the Form A filing projections, is not adequate to achieve appropriate RBC levels. As a result, there will be continued pressure (under both Without Conversion and With Conversion scenarios) to increase rating margins to support the needed/adequate surplus requirements. Also, with or without conversion, the competitive market for insurance will continue to constrain potential rating margins.

Note that the dynamics of these projections are relatively complex. Initial surplus requirements can be affected by any number of variables, including but not limited to the timing of losses, capital investments, trends, and membership growth. Values shown in Table 1 are prefaced on Form A assumptions with respect to members, trend, administrative expenses, premium, and capital expenditures. The simulation process for Table 1 values assumed Form A inputs for items other than claims, then derived claim levels required to produce a fixed (percentage rate) underwriting loss in each year. Details of each scenario are shown in Exhibits 3a-3c.

For both scenarios, the modeling simulated the aggregate C&R (margin) required to attain a target level of surplus at the end of the projection period[10], given assumptions about other components of the premium rate structure. The Without Conversion modeling is described first, followed by With Conversion scenario modeling.

B. Scenarios

1. Without Conversion Modeling

   a. Rating Margin:

      Given Table 1 surplus level targets, the key step in our Scenario 1 modeling was to estimate rating margins that, when coupled with associated investment income, would generate the desired level of surplus at the end of the five year projection period. Table 2 shows the results of this analysis.

[9] Modeling assumes the Without Conversion premium tax assumption for Alaska, but conclusions would be virtually identical using With Conversion assumptions.

[10] Defined as a percentage of annualized underwritten premium.

Table 2
Rating Margin Required to Achieve Desired Level of Surplus

Desired Certainty/Safety Threshold	Rating Margin (pct)	CY 2008 Ending Surplus ($million)	CY 2008 Ending Surplus Benchmark (pct)	CY2008 Ending ACL Multiple
75th Percentile	3.2%	$1,148	19.8%	6.3
90th Percentile	4.9%	$1,487	25.2%	8.1
95th Percentile	6.7%	$1,858	30.9%	10.2

As shown, rating margins ranging from 3.2%-6.7% of premium would be required to achieve Table 1 target surplus levels over a five-year period.[11] Detailed projections leading up to Table 2 values are provided as Exhibits 4a-4c.

In our opinion, it is very unlikely that surplus could be built to 30% of ending premium over a five-year period without compromising other aspects of the business plan. On the other hand, we also believe that the 75th percentile represents a minimum safety threshold. After considering these constraints, we conclude that it would be reasonable to target a 4% rating margin for underwritten business to the extent practicable.

b. Premium Rates:

Table 3 shows year-to-year progressions of modeled premiums, surplus levels, percent of premium benchmarks, and ACL multiples given a hypothetical 4% rating margin; note that PMPM premium amounts correspond to those shown in Table 6.

Table 3
Modeled Non-Conversion PMPM Premiums With a 4% Average Premium Margin

Item	2004	2005	2006	2007	2008
PMPM Premium	PROPRIETARY MATERIAL REDACTED				
Ending Surplus					
Dollars ($million)					
% of Premium					
ACL Multiple	4.7	5.4	6.0	6.6	7.1

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[11] We also note that the approximate [ ] rating margin shown in the Form A filing does not appreciably increase surplus relative to ACL benchmarks.

Detailed projections supporting Table 3 results are shown in Exhibit 5.

2. With Conversion Modeling

Similar to Scenario 1, Scenario 2 projections are based on Form A filing assumptions. Since few aspects of PBC's operations are expected to change following conversion, modeling under each scenario follows a similar course. The specific assumptions unique to Scenario 2 are:

- Alaska Premium Tax - As described in Section 3, premium taxes in Alaska are expected to be higher for following conversion. This change exerts modest upward pressure on premium rates, all other factors held constant,

- Investable Assets - Based on conversations with PBC staff, it is reasonable to assume that the conversion process could increase assets available for investment (and hence surplus) by approximately $100 million. Accordingly, the starting level of investment assets assumed for Scenario 2 was set at $100 million above Scenario 1.

a. Surplus Objective:

The forces that affect PBC's surplus requirements today will remain following conversion. In particular, the conversion cannot affect the underlying cycles characteristic of the health insurance business. While the expected increase in surplus at conversion will improve PBC's risk posture and RBC position, the related ACL multiples would still not meet benchmarks modeled under Scenario 1.

We note that the use of the same surplus level objective as that used in the Without Conversion scenario is conservative.[12] The ability to access the capital markets offers a for-profit company an additional vehicle (in addition to retained earnings) with which to fund capital needs. Arguably, then, the surplus requirements of a for-profit entity are somewhat lower than those for a not-for-profit counterpart. Clearly, however, surplus should still remain comfortably above minimum levels that would presage regulatory intervention.

[12] All other assumptions held equal. If a lower surplus objective for Scenario 2 was assumed, the resulting rating margins and premium rates would be lower.

b. Rating Margin:

For Scenario 2, we calculated the level premium rating margin required to match the surplus amount modeled under Scenario 1. Calculation details are shown in Exhibit 6. The modeled premium margin is 3.4%.

Of course, the evaluation of applicable rating margins targets following conversion to a for-profit company must reflect a balance among many factors. Investors in the for-profit company are entitled to a reasonable return on their investment, and premium margins are the most obvious channel for achieving this return. However, gross premium margin alone is not a sufficient evaluation criterion, since the optimization of total profit involves a trade-off between membership and rating margins. As previously noted, the competitive nature of the market for health insurance limits the average percentage profit that can be achieved on a given group or subscriber. A carrier that pursues profit margins too aggressively is likely to miss growth targets.

In assessing the reasonableness of the calculated rating margin for Scenario 2, we studied margins recently achieved in the marketplace by for-profit Blue Plans, as well as the not-for-profit Blue counterparts. Table 4 summarizes operating results for 2000-2002 publicly traded health insurers.

Table 4
Operating Margin for Publicly Traded Health Insurers [13]

	Year Ending		
Company Type	**6/30/2000**	**6/30/2001**	**6/30/2002**
Public Blues	4.0%	4.3%	5.0%
Public Non-Blues	2.0%	1.5%	4.1%

As can be seen, "Public" carriers have tended to achieve operating margins on the order of 2-5%. The calculated 3.4% margin under Scenario 2 is clearly within this range.

[13] June 2000 values taken from *Pulse*, December 2001, while remaining values taken from *Pulse*, December 2002.

c. Premium Rates:

Table 5 shows year-to-year progressions of modeled premiums, surplus levels, percent of premium benchmarks, and ACL multiples given the 3.4% rating margin.[14]

Table 5
Modeled With Conversion PMPM Premiums by Calendar Year

Item	2004	2005	2006	2007	2008
PMPM Premium	PROPRIETARY MATERIAL REDACTED				
Ending Surplus					
Dollars ($million)					
% of Premium					
ACL Multiple	5.5	6.0	6.4	6.8	7.1

C. *Comparison*

The final step was to compare modeled Without Conversion premiums to With Conversion counterparts; results are shown in Table 6.

Table 6
Comparison of Modeled PMPM Premiums, With and Without Conversion

Scenario	Description	2004 PMPM	2005 PMPM	2006 PMPM	2007 PMPM	2008 PMPM
1	Without Conversion	PROPRIETARY MATERIAL REDACTED				
2	With Conversion					
	Difference (1)/(2)-1	0.5%	0.5%	0.5%	0.5%	0.5%

As shown, modeled rates are similar under both scenarios. Note also that rate *differences* are much more important than absolute rate *levels*.

[14] Modeling implicitly assumes that PBC would not seek additional equity capital, and that no earnings will be released as shareholder dividends.

Section 5: Conclusions

Based on our analysis and findings discussed in this report, we have the following conclusions:

1. *Premium Rate Components* – Other than a relatively small increase in Alaska premium tax, the conversion is unlikely to generate changes in the components of PBC's premium rate structure.
2. *Premium Rates* – PBC's conversion from a non-profit to for-profit health insurance company is not likely to result in any material impact on its premium rates.

Section 6: Exhibits

Premera Blue Cross
Comparative Premium Rate Analysis
Exhibit 1
CPRA Model: Baseline Values from Form A Filing

	Insured Business				ASC Business					
Year	Average Members	Claims	Admin	Premium	Average Members	Administrative Fees	Expenses	Income	Projected Surplus	Percent of Underwritten Premium
2003										
2004										
2005										
2006										
2007										
Total										

PROPRIETARY MATERIAL REDACTED

Note all values in ,000 unless otherwise noted.

Premera Blue Cross
Comparative Premium Rate Analysis
Exhibit 2

Underwriting Loss Cycles for Blue Cross Blue Shield "Peer Group" Plans [1]
from 1980 through 2001
Sorted By Descending Total Loss

Rank	Percentile	Percent UW Loss [2]
1		26.3%
2	95th	24.6%
3		22.9%
4		20.7%
5		19.5%
6	90th	19.4%
7		19.3%
8		17.3%
9		16.4%
10		16.1%
11	75th	14.7%
12		14.4%
13		13.9%
14		13.7%
15		12.7%
16		12.5%
17		12.2%
18		12.1%
19		12.0%
20		11.9%
21		11.5%
22		11.4%
23		11.3%
24	50th	10.5%
25		9.7%
26		9.3%
27		8.6%
28		8.5%
29		8.3%
30		8.2%
31		8.2%
32		7.8%
33		7.7%
34		7.5%
35		5.9%
36		5.7%
37	25th	5.6%
38		5.3%
39		5.3%
40		4.7%
41		4.3%
42		3.9%
43		3.9%
44		2.1%
45		1.1%
46		0.7%

Note:

[1] Based on experience from 15 Blue Cross Blue Shield plans.

[2] Loss measured as Total Loss over the Underwriting Cycle ÷ Average Annual Net Revenue.

Premera Blue Cross
Comparative Premium Rate Analysis
Exhibit 3a
CPRA Model: Simulated Operations Over Underwriting Down Cycle

Key Assumptions

Assumptions	
Enrollment assumptions	Form A Filing
Claims pmpm assumptions	Derived Based on Loss Scenario
Rating Margin	Derived Based on Loss Scenario (see below)
Administrative Costs (include premium tax and commissions)	See tab 'Input Form A'
2003 Claims Expense ($,000)	(used to model IBNR portion of investable assets)
Average Days of Expense in Reserve	claim liabilities/(benefit expense)*365
Approximate 100% ACL Level	(of insured claims)
Tax Rate	
Return on Investable Assets	
Starting Investable Assets ($,000s)	(preserve the same relationship as in rating margin simulations)
2003 Insured Premium ($,000s)	
Required Starting Surplus ($,000s)	
Starting Surplus (% 2003 Insured Premium)	
Loss Scenario:	
Percentile	
Cumulative Loss over Cycle	

PROPRIETARY MATERIAL REDACTED

Key Output (all values in ,000 unless otherwise noted)

	Insured Business					ASC Business									Earnings			Surplus			
Year	Average Members	Claims	Admin	Rating Margin	Premium	Average Members	Administrative Fees	Expenses	Additional Margin	Income	Investable Assets	Capital Expenditures	Depreciation/ Amortization	Investment Income	Gross	Tax	Net	Beginning	Net Addition	Ending	ACL Multiple
2004																					
2005																					
2006																					
2007																					
2008																					
Total																					

PROPRIETARY MATERIAL REDACTED

PMPM Values

	Insured Business					ASC Business									Earnings			Surplus		
Year	Average Members	Claims	Admin	Rating Margin	Premium	Average Members	Administrative Fees	Expenses	Additional Margin	Income	Investable Assets	Capital Expenditures	Depreciation/ Amortization	Investment Income	Gross	Tax	Net	Beginning	Net Addition	Ending
2004																				
2005																				
2006																				
2007																				
2008																				
Total																				

PROPRIETARY MATERIAL REDACTED

Premera Blue Cross
Comparative Premium Rate Analysis
Exhibit 3b
CPRA Model: Simulated Operations Over Underwriting Down Cycle

Key Assumptions

Assumptions	
Enrollment assumptions	Form A Filing
Claims pmpm assumptions	Derived Based on Loss Scenario
Rating Margin	Derived Based on Loss Scenario (see below)
Administrative Costs (Include premium tax and commissions)	See tab 'Input Form A'
2003 Claims Expense ($,000)	(used to model IBNR portion of investable assets)
Average Days of Expense in Reserve	claim liabilities/(benefit expense)*365
Approximate 100% ACL Level	of insured claims)
Tax Rate	
Return on Investable Assets	
Starting Investable Assets ($,000s)	preserve the same relationship as in rating margin simulations)
2003 Insured Premium ($,000s)	
RequiredStarting Surplus ($,000s)	
Starting Surplus (% 2003 Insured Premium)	[PROPRIETARY MATERIAL REDACTED
Loss Scenario:	
Percentile	
Cumulative Loss over Cycle	

Key Output (all values in ,000 unless otherwise noted)

	Insured Business					ASC Business												Surplus			
Year	Average Members	Claims	Admin	Rating Margin	Premium	Average Members	Administrative Fees	Expenses	Additional Margin	Income	Investable Assets	Capital Expenditures	Depreciation/ Amortization	Investment Income	Earnings Gross	Earnings Tax	Earnings Net	Beginning	Net Addition	Ending	ACL Multiple
2004	PROPRIETARY MATERIAL REDACTED																				
2005																					
2006																					
2007																					
2008																					
Total																					

PMPM Values

	Insured Business					ASC Business												Surplus		
Year	Average Members	Claims	Admin	Rating Margin	Premium	Average Members	Administrative Fees	Expenses	Additional Margin	Income	Investable Assets	Capital Expenditures	Depreciation/ Amortization	Investment Income	Earnings Gross	Earnings Tax	Earnings Net	Beginning	Net Addition	Ending
2004	PROPRIETARY MATERIAL REDACTED																			
2005																				
2006																				
2007																				
2008																				
Total																				

Premera Blue Cross
Comparative Premium Rate Analysis
Exhibit 3c
CPRA Model: Simulated Operations Over Underwriting Down Cycle

Key Assumptions

Assumptions	
Enrollment assumptions	Form A Filing
Claims pmpm assumptions	Derived Based on Loss Scenario
Rating Margin	Derived Based on Loss Scenario (see below)
Administrative Costs (include premium tax and commissions)	See tab 'Input Form A'
2003 Claims Expense ($,000)	(used to model IBNR portion of investable assets)
Average Days of Expense in Reserve	claim liabilities/(benefit expense)*365
Approximate 100% ACL Level	% of insured claims)
Tax Rate	
Return on Investable Assets	
Starting Investable Assets ($,000s)	(preserve the same relationship as in rating margin simulations)
2003 Insured Premium ($,000s)	
RequiredStarting Surplus ($,000s)	PROPRIETARY MATERIAL REDACTED
Starting Surplus (% 2003 Insured Premium)	
Loss Scenario:	
Percentile	
Cumulative Loss over Cycle	

Key Output (all values in ,000 unless otherwise noted)

	Insured Business					ASC Business									Earnings			Surplus			
Year	Average Members	Claims	Admin	Rating Margin	Premium	Average Members	Administrative Fees	Expenses	Additional Margin	Income	Investable Assets	Capital Expenditures	Depreciation/ Amortization	Investment Income	Gross	Tax	Net	Beginning	Net Addition	Ending	ACL Multiple
2004																					
2005																					
2006																					
2007																					
2008																					
Total																					

PROPRIETARY MATERIAL REDACTED

PMPM Values

	Insured Business					ASC Business									Earnings			Surplus		
Year	Average Members	Claims	Admin	Rating Margin	Premium	Average Members	Administrative Fees	Expenses	Additional Margin	Income	Investable Assets	Capital Expenditures	Depreciation/ Amortization	Investment Income	Gross	Tax	Net	Beginning	Net Addition	Ending
2004																				
2005																				
2006																				
2007																				
2008																				
Total																				

PROPRIETARY MATERIAL REDACTED

Premera Blue Cross
Comparative Premium Rate Analysis
Exhibit 4a
CPRA Model: Key Assumption and Projection Value Summaries

Key Assumptions

Common Assumptions	
Enrollment assumptions	See tab 'Input Form A'
Claims pmpm assumptions	See tabs 'Input Form A' and 'Model Calcs'
Admin (include premium tax and commissions)	See tab 'Input Form A'
2003 Claims Expense	
Average Days of Expense in Reserve	Claims Liabilities/(Benefit Expense/365)
Approximate 100% ACL Level	(of insured claims)
GAAP Surplus - Stat Surplus ($,000)	Form A Filing

Scenario-Specific Assumptions	
Tax Rate	PROPRIETARY MATERIAL REDACTED
Return on Investable Assets	
Starting Investable Assets ($,000s)	
Starting Surplus ($,000s)	
Market Capitalization after Conversion ('000s)	
Additional Capital from Conversion (IPO)	
Margin in Insured Premium Rates	
Ending Surplus (% Insured Premium)	

Key Output (all values in ,000 unless otherwise noted)

No Conversion or Growth

	Insured Business					ASC Business									Earnings			Surplus			
Year	Average Members	Claims	Admin	Rating Margin	Premium	Average Members	Administrative Fees	Expenses	Additional Margin	Income	Investable Assets	Capital Expenditures	Depreciation/ Amortization	Investment Income	Gross	Tax	Net	Beginning	Net Addition	Ending	ACL Multiple
2004	PROPRIETARY MATERIAL REDACTED																				
2005																					
2006																					
2007																					
2008																					
Total																					

PMPM Values

	Insured Business					ASC Business									Earnings			Surplus		
Year	Average Members	Claims	Admin	Rating Margin	Premium	Average Members	Administrative Fees	Expenses	Additional Margin	Income	Investable Assets	Capital Expenditures	Depreciation/ Amortization	Investment Income	Gross	Tax	Net	Beginning	Net Addition	Ending
2004	PROPRIETARY MATERIAL REDACTED																			
2005																				
2006																				
2007																				
2008																				
Total																				

Premera Blue Cross
Comparative Premium Rate Analysis
Exhibit 4b
CPRA Model: Key Assumption and Projection Value Summaries

Key Assumptions

Common Assumptions	
Enrollment assumptions	See tab 'Input Form A'
Claims pmpm assumptions	See tabs 'Input Form A' and 'Model Calcs'
Admin (include premium tax and commissions)	See tab 'Input Form A'
2003 Claims Expense	
Average Days of Expense in Reserve	Claims Liabilities/(Benefit Expense/365)
Approximate 100% ACL Level	(of insured claims)
GAAP Surplus - Stat Surplus ($,000)	Form A Filing
Scenario-Specific Assumptions	
Tax Rate	PROPRIETARY MATERIAL REDACTED
Return on Investable Assets	
Starting Investable Assets ($,000s)	
Starting Surplus ($,000s)	
Market Capitalization after Conversion ('000s)	
Additional Capital from Conversion (IPO)	
Margin in Insured Premium Rates	
Ending Surplus (% Insured Premium)	

Key Output (all values in ,000 unless otherwise noted)

No Conversion or Growth

	Insured Business					ASC Business									Earnings			Surplus			
Year	Average Members	Claims	Admin	Rating Margin	Premium	Average Members	Administrative Fees	Expenses	Additional Margin	Income	Investable Assets	Capital Expenditures	Depreciation/ Amortization	Investment Income	Gross	Tax	Net	Beginning	Net Addition	Ending	ACL Multiple
2004	PROPRIETARY MATERIAL REDACTED																				
2005																					
2006																					
2007																					
2008																					
Total																					

PMPM Values

	Insured Business					ASC Business									Earnings			Surplus		
Year	Average Members	Claims	Admin	Rating Margin	Premium	Average Members	Administrative Fees	Expenses	Additional Margin	Income	Investable Assets	Capital Expenditures	Depreciation/ Amortization	Investment Income	Gross	Tax	Net	Beginning	Net Addition	Ending
2004	PROPRIETARY MATERIAL REDACTED																			
2005																				
2006																				
2007																				
2008																				
Total																				

Premera Blue Cross
Comparative Premium Rate Analysis
Exhibit 4c
CPRA Model: Key Assumption and Projection Value Summaries

Key Assumptions

Common Assumptions	
Enrollment assumptions	See tab 'Input Form A'
Claims pmpm assumptions	See tabs 'Input Form A' and 'Model Calcs'
Admin (include premium tax and commissions)	See tab 'Input Form A'
2003 Claims Expense	
Average Days of Expense in Reserve	Claims Liabilities/(Benefit Expense/365)
Approximate 100% ACL Level	(of insured claims)
GAAP Surplus - Stat Surplus ($,000)	Form A Filing

Scenario-Specific Assumptions	PROPRIETARY MATERIAL REDACTED
Tax Rate	
Return on Investable Assets	
Starting Investable Assets ($,000s)	
Starting Surplus ($,000s)	
Market Capitalization after Conversion ('000s)	
Additional Capital from Conversion (IPO)	
Margin in Insured Premium Rates	
Ending Surplus (% Insured Premium)	

Key Output (all values in ,000 unless otherwise noted)

No Conversion or Growth

	Insured Business					ASC Business											Surplus			
															Earnings					
Year	Average Members	Claims	Admin	Rating Margin	Premium	Average Members	Administrative Fees	Expenses	Additional Margin	Income	Investable Assets	Capital Expenditures	Depreciation/ Amortization	Investment Income	Gross	Tax	Net	Beginning	Net Addition	Ending	ACL Multiple
2004	PROPRIETARY MATERIAL REDACTED																				
2005																					
2006																					
2007																					
2008																					
Total																					

PMPM Values

	Insured Business					ASC Business											Surplus		
															Earnings					
Year	Average Members	Claims	Admin	Rating Margin	Premium	Average Members	Administrative Fees	Expenses	Additional Margin	Income	Investable Assets	Capital Expenditures	Depreciation/ Amortization	Investment Income	Gross	Tax	Net	Beginning	Net Addition	Ending
2004	PROPRIETARY MATERIAL REDACTED																			
2005																				
2006																				
2007																				
2008																				
Total																				

Premera Blue Cross
Comparative Premium Rate Analysis
Exhibit 5
CPRA Model: Key Assumption and Projection Value Summaries

Key Assumptions

Common Assumptions	
Enrollment assumptions	See tab 'Input Form A'
Claims pmpm assumptions	See tabs 'Input Form A' and 'Model Calcs'
Admin (include premium tax and commissions)	See tab 'Input Form A'
2003 Claims Expense	
Average Days of Expense in Reserve	Claims Liabilities/(Benefit Expense/365)
Approximate 100% ACL Level	(of Insured claims)
GAAP Surplus - Stat Surplus ($,000)	Form A Filing
Scenario-Specific Assumptions	
Tax Rate	PROPRIETARY MATERIAL REDACTED
Return on Investable Assets	
Starting Investable Assets ($,000s)	
Starting Surplus ($,000s)	
Market Capitalization after Conversion ('000s)	
Additional Capital from Conversion (IPO)	
Margin in Insured Premium Rates	
Ending Surplus (% Insured Premium)	

Key Output (all values in ,000 unless otherwise noted)

No Conversion or Growth

	Insured Business					ASC Business									Earnings			Surplus			
Year	Average Members	Claims	Admin	Rating Margin	Premium	Average Members	Administrative Fees	Expenses	Additional Margin	Income	Investable Assets	Capital Expenditures	Depreciation/ Amortization	Investment Income	Gross	Tax	Net	Beginning	Net Addition	Ending	ACL Multiple
2004	PROPRIETARY MATERIAL REDACTED																				
2005																					
2006																					
2007																					
2008																					
Total																					

PMPM Values

	Insured Business					ASC Business									Earnings			Surplus		
Year	Average Members	Claims	Admin	Rating Margin	Premium	Average Members	Administrative Fees	Expenses	Additional Margin	Income	Investable Assets	Capital Expenditures	Depreciation/ Amortization	Investment Income	Gross	Tax	Net	Beginning	Net Addition	Ending
2004	PROPRIETARY MATERIAL REDACTED																			
2005																				
2006																				
2007																				
2008																				
Total																				

Premera Blue Cross
Comparative Premium Rate Analysis
Exhibit 6
CPRA Model: Key Assumption and Projection Value Summaries

Key Assumptions

Common Assumptions	
Enrollment assumptions	See tab 'Input Form A'
Claims pmpm assumptions	See tabs 'Input Form A' and 'Model Calcs'
Admin (include premium tax and commissions)	See tab 'Input Form A'
2003 Claims Expense	
Average Days of Expense in Reserve	Claims Liabilities/(Benefit Expense/365)
Approximate 100% ACL Level	(of Insured claims)
GAAP Surplus - Stat Surplus ($,000)	Form A Filing

Scenario-Specific Assumptions	
Tax Rate	PROPRIETARY MATERIAL REDACTED
Return on Investable Assets	
Starting Investable Assets ($,000s)	
Starting Surplus ($,000s)	
Market Capitalization after Conversion ('000s)	
Additional Capital from Conversion (IPO)	
Margin in Insured Premium Rates	

Key Output (all values in ,000 unless otherwise noted)

With Conversion

	Insured Business					ASC Business									Earnings			Surplus			
Year	Average Members	Claims	Admin	Rating Margin	Premium	Average Members	Administrative Fees	Expenses	Additional Margin	Income	Investable Assets	Capital Expenditures	Depreciation/ Amortization	Investment Income	Gross	Tax	Net	Beginning	Net Addition	Ending	ACL Multiple
2004	PROPRIETARY MATERIAL REDACTED																				
2005																					
2006																					
2007																					
2008																					
Total																					

PMPM Values

	Insured Business					ASC Business									Earnings			Surplus		
Year	Average Members	Claims	Admin	Rating Margin	Premium	Average Members	Administrative Fees	Expenses	Additional Margin	Income	Investable Assets	Capital Expenditures	Depreciation/ Amortization	Investment Income	Gross	Tax	Net	Beginning	Net Addition	Ending
2004	PROPRIETARY MATERIAL REDACTED																			
2005																				
2006																				
2007																				
2008																				
Total																				

Addendum

Geographic Rating for Individual and Small Group Business in Washington

Introduction

PricewaterhouseCoopers, LLP (PwC) submitted a report on October 27, 2003 entitled "Economic Impact Analysis of the Proposed Conversion of Premera Blue Cross for the State of Washington." This report contains the following observation:

> "Premera may be able to increase operating margins in geographical markets and lines of business where the company has dominant market share. This ability is largely limited to areas in Eastern Washington and to individual and small group lines of business. The Dimensions product may allow Premera to increase rates faster than health care trend for these members and remain within state rate setting regulations for these products."[1]

The geographic markets referred to by PwC are apparently counties, or collections of counties, primarily in Eastern Washington[2]

After the PwC report was submitted, PBC asked Milliman evaluate Washington law applicable to insurers like Premera, with particular focus on the individual and small group markets. Considering rate regulation, market forces, and actuarial standards of practice, we were also asked to comment on the extent to which a carrier with market power might use rating actions to achieve substantial, sustained profit margins in selected geographic areas.

Based on our analysis of actuarial standards of practice and regulatory requirements in the state of Washington, we conclude it is very unlikely that PBC (or any other carrier) could posture its rate development to achieve and maintain substantial rating margins for individual and small group products in selected geographic markets.

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[1] PricewaterhouseCoopers, "Economic Impact Analysis of the Proposed Conversion of Premera Blue Cross for the State of Washington", (October 27, 2003) page ES 6 (hereinafter PwC Economic Report)

[2] PwC Economic Report, page 122; "any attempt to increase premium rates above medical trend will more likely affect members in Eastern Washington counties where Premera has dominant market share and, within these counties, those members who are enrolled in Individual and regulated small group (1-50 employees) products." (emphasis added)

Analysis

Our analysis of this issue included review of applicable law, technical advisories and actuarial practice standards. Based on our review of this material and our experience in the health insurance field, we note the following:

1. The individual and small group markets in Washington are regulated and rate filings are closely reviewed. In our experience, the OIC a) can and will exercise its authority to mitigate rate actions it deems to be excessive, and b) requires more documentation of rating formulas and factors, and reviews submissions more carefully than regulatory bodies in many other states.

2. Relative to most other states observed, the rating and underwriting requirements in Washington are favorably balanced toward consumers. This orientation, coupled with applicable (or effective) loss ratio standards, sets a practical limit on potential rating margins for individual and small group business.

   - Underwriting is standardized for individual business, and carriers must accept all applicants that meet specified criteria. In contrast, individual carriers in many other states have significant control over underwriting standards, and may issue policies with restrictive riders.

   - Rates for individuals and specific small groups can only reflect selected 'case characteristics' as defined under the NAIC Model Small Group Regulations. In fact, two common case characteristics (gender and industry) cannot be used to distinguish rates for otherwise identical groups. Furthermore, and in contrast to standards in many other states, carriers in Washington cannot use health status and/or claims experience to set group-specific rates, which makes insurance coverage significantly more affordable to high cost and/or high utilization groups.

   - The minimum loss ratio for individual business in Washington is higher than the standard in most other states.

3. While no statutory loss ratio requirement applies to small group business in Washington, Washington Administrative Code 284-43-915 establishes stringent safe harbors for the required demonstration that benefits and services to be provided are reasonable in relation to the amount charged. One such safe harbor stipulates an anticipated loss ratio of 80% or more, and an increase in the community rate that is not more than 3% above Medical CPI. If this safe harbor is not met, all components of the premium rate must be 'actuarially sound' and/or 'actuarially prudent'.

4. Individuals and groups are not required to purchase insurance coverage in Washington. On the other hand, carriers are required to offer coverage to individuals (that pass uniform underwriting) and groups, and to continue offering coverage to high cost members. Even in the absence of effective competition, an increase in premium rates is likely to lead to a decrease in demand for insurance. Further, those individuals and groups that retain coverage in the face of rate increases are typically those most likely to use medical services. In our experience, the potential increase in profit margin associated with a significant increase in premium is likely to be eroded or reversed through selective lapse.

5. Individual and small group business is typified by low average premium, high turnover, and high per unit acquisition costs. These factors tend to increase the percent of total premium dollars that must be set aside for administrative expenses. Coupled with the line-specific loss ratio requirements, these factors combine to effectively constrain rating margins.

6. The standard actuarial approach for developing Adjusted Community Rate (ACR) rates (as used by PBC for its individual and small group business) derives total required revenue as expected incurred claims over the entire state, divided by the target loss ratio. The target loss ratio is a single value that does not vary by geographic region. Thus, an insurer – such as PBC - that uses this approach cannot modify the loss ratio target to increase rates in one region without also increasing rates in another region. The sole way to increase rates for selected regions is through use of geographic factors.

7. While Washington law itself contains limited guidance on standards for geographic rate variation, technical advisory TA-2000-007 offers some clarification. Our interpretation of this advisory suggests the following constraints:

   - Geographic factors cannot be based on actual claims experience (either favorable, or unfavorable),
   - Factors must be based on statistically credible data,
   - Factors must be related to the expected 'cost' of the product, which excludes the desired differences in profit/risk by region, and
   - A restricted network (such as Dimensions) cannot be used to justify differences in rates unless there are associated differences in network costs.

   In short, the guidance offered precludes a carrier from using geographic factors to derive substantially different rating margins by region.

8. It would be contrary to actuarial standards to target a materially different loss ratio for specific products within a given line of business, especially on a region-by-region basis. For instance, it would be inappropriate to target a materially different loss ratio – particularly by region – for the small group Dimensions product than for other small group offerings. It would also be contrary to standard actuarial practice to establish a loss ratio target for any material product (within a product line) that is lower than the applicable statutory minimum.

Findings

Based on our analysis, we find that:

- The only way for a carrier to achieve regional-specific rate variation for individual and small group products is through use of geographic factors.

- Geographic factors must be based on 'credible data or a large study'. A carrier cannot change geographic factors based simply on whim, or a desire to significantly improve rating margins in a given part of the state.

- Actuaries certify filed rates as being reasonable in relation to benefits provided. Intentional use of a geographic factor to substantially increase profit margins in one region would belie the professional opinion offered in the actuarial certification.

- The OIC's close review of rate filings in the state, particularly for the larger carriers, ensures a high likelihood that any attempted gamesmanship would be discovered. As well, periodic public filing of financial results would reveal significant profit levels, and likely lead to subsequent adjustments.

Conclusion

Based on the foregoing, we believe that it is virtually impossible for PBC – or any other significant carrier – to use geographic factors to achieve a significant improvement in individual and/or small group rating margins in Washington. Further, any margin so achieved would likely be quickly reversed through a combination of regulatory review, provider backlash, competition, and/or anti-selective lapses.

Our conclusion is based on the following:

- It would be contrary to an OIC interpretive bulletin and standard actuarial practice to include differences in desired rating margins to justify geographic rating factors,

- Carriers in Washington are subject to product-specific loss ratio requirements for individual products that effectively limit potential rating margins,

- Rates for individual and small group products are subject to OIC review. The OIC can disapprove rate filings that do not comply with applicable regulations, and

- Consumers are not forced to buy health insurance. Any unwarranted rate increase by Premera (or any other company) is likely to decrease sales, weaken persistence, and may ultimately reduce profits.

Appendix to Addendum

This appendix contains seven parts: Introduction, Synopsis of Applicable Law, Actuarial Standards of Practice, General Rate Requirements, Commercial Individual Requirements, Commercial Small Group Requirements, and Technical Advisories

Introduction

This appendix provides references for applicable law and actuarial practice standards related to rate development for commercial individual and small group business in Washington.

Most **statutes** applicable to PBC's commercial individual and small group business are found in Chapters 48.43 and 48.44 of the Revised Code of Washington (RCW). Associated **regulations** are found in Chapters 284-43 and 284-44 of the Washington Administrative Code (WAC).[3] Selected passages are included below.

The OIC also issues periodic **technical advisories** to clarify issues not completely addressed in the RCW or WAC. One such advisory of relevance to geographical rate variation was issued in 2000, and is included below.

Finally, the Society of Actuaries (SOA) and American Academy of Actuaries (AAA) have developed standards that govern actuarial work-product, including development and submission of rate filings.

Synopsis of Applicable Law

Based on our review of the statues and regulations, the following standards apply to rates for commercial individual and small group business.

1. As provided in RCW 48.44.022 and 48.44.023, carriers are required to use an ACR approach to set individual and group-specific rates. The only permissible small group rating variables (in addition to product and effective date) are geographic area, family size, age, and wellness activities; for individual products, a tenure discount of up to 10% is also allowed after two years of continuous coverage. Permissible ranges of values for some of these rating variables are also limited.

2. RCW 48.44.017 establishes a minimum loss ratio for individual business of 74%, less any applicable premium tax. Rate filings must include a certification by a Member of the American Academy of Actuaries (MAAA), or other person approved by the OIC, that the loss ratio requirement is met.

[3] We understand that PBC would continue to be subject to these statutes and regulations following conversion.

3. For both individual and small group filings, WAC 284-43-930 requires certification by an actuary that the benefits and services to be provided are reasonable in relation to the amount charged.

4. RCW 48.44.020 (3) provides that rates for small groups may be disapproved if the rates are not reasonable in relation to the benefits provided. While no statutory loss ratio requirement applies to small group business in Washington, WAC 284-43-915 establishes safe harbors for demonstrating that benefits and services to be provided are reasonable in relation to the amount charged.

5. The State of Washington requires an actuarial certification for all individual and small group rate filings.[4] This certification requires that the actuary be familiar with applicable laws and regulations of the State of Washington for the filing requirements applicable to health care service contractors. The actuary must be a member of the American Academy of Actuaries (or be deemed competent to so act by the Commissioner).

Actuarial Standards of Practice

Members of the American Academy of Actuaries are required to adhere to their Revised Code of Professional Conduct, pertinent portions of which are set forth below.

From the "Revised Code of Professional Conduct"

The purpose of this Code of Professional Conduct ("Code") is to require Actuaries to adhere to the high standards of conduct, practice, and qualifications of the actuarial profession, thereby supporting the actuarial profession in fulfilling its responsibility to the public. An Actuary shall comply with the Code. An Actuary who commits a material violation of the provisions of the Code shall be subject to the profession's counseling and discipline procedures.

The Precepts of the Code identify the professional and ethical standards with which an Actuary must comply in order to fulfill the Actuary's responsibility to the public and to the actuarial profession. The Annotations provide additional explanatory, educational, and advisory material on how the Precepts are to be interpreted and applied.

In addition to this Code, an Actuary is subject to applicable rules of professional conduct or ethical standards that have been promulgated by a Recognized Actuarial Organization for the jurisdictions in which the Actuary renders Actuarial Services. Actuarial Services are considered to be rendered in the jurisdictions in which the Actuary intends them to be used unless specified otherwise by an agreement between a Recognized Actuarial Organization for any such jurisdiction and the organizations that have adopted the Code.

[4] RCW 48.44.017 and WAC 284-42-930

Laws may also impose obligations upon an Actuary. Where requirements of Law conflict with the Code, the requirements of Law shall take precedence.

An Actuary must be familiar with, and keep current with, not only the Code, but also applicable Law and rules of professional conduct for the jurisdictions in which the Actuary renders Actuarial Services. An Actuary is responsible for securing translations of such Laws or rules of conduct as may be necessary.

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PRECEPT 1. An Actuary shall act honestly, with integrity and competence, and in a manner to fulfill the profession's responsibility to the public and to uphold the reputation of the actuarial profession.

ANNOTATION 1-2. An Actuary shall not provide Actuarial Services for any Principal if the Actuary has reason to believe that such services may be used to violate or evade the Law or in a manner that would be detrimental to the reputation of the actuarial profession.

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PRECEPT 3. An Actuary shall ensure that Actuarial Services performed by or under the direction of the Actuary satisfy applicable standards of practice.

ANNOTATION 3-1. It is the professional responsibility of an Actuary to observe applicable standards of practice that have been promulgated by a Recognized Actuarial Organization for the jurisdictions in which the Actuary renders Actuarial Services, and to keep current regarding changes in these standards.

ANNOTATION 3-2. Where a question arises with regard to the applicability of a standard of practice, or where no applicable standard exists, an Actuary shall utilize professional judgment, taking into account generally accepted actuarial principles and practices.

ANNOTATION 3-3. When an Actuary uses procedures that depart materially from those set forth in an applicable standard of practice, the Actuary must be prepared to justify the use of such procedures.

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General Rate Requirements

The following sections provide specific references from RCW, WAC, and technical advisories cited earlier.

WAC 284-43-925

General contents of all filings. Each filing required to be made pursuant to WAC 284-43-920 shall be submitted with the filing transmittal form prescribed by and available from the commissioner. The form will include the name of the filing entity, its address, identification number, the type of filing being submitted, the form name or group name and number, and other relevant information. Filings shall also include the information required on the filing summary set forth in WAC 284-43-945 for individual and small group plans and rate schedules or as set forth in WAC 284-43-950 for group plans and rate schedules other than those for small groups.

WAC 284-43-930

Contents of individual and small group filings. Under RCW 48.44.022(3) and 48.46.064(3) the experience of all individual plans shall be pooled; and under RCW 48.44.023 (3)(i) and 48.46.066 (3)(i) the experience of all small group plans shall be pooled. Filings for individual plans shall include base rates for all individual plans and filings for small group plans shall include base rates for all small group plans. Each individual and small group filing shall include all of the following information and documents:

(1) An actuarially sound estimate of incurred claims. Experience data, assumptions, and justifications of the carrier's projected incurred claims shall be provided in a manner consistent with the carrier's rate-making methodology and incorporate the following elements:

(a) A brief description of the carrier's rate-making methodology, including identification of the data used and the kinds of assumptions and projections made.

(b) The number of subscribers by family size, or covered persons for the plans included in the filing. These figures shall be shown for each month or quarter of the experience period and the prior two periods if not included in previous filings. This data shall be presented in aggregate for the plans included in the filing and in aggregate for all of the carrier's plans.

(c) Earned premium for each month or quarter of the experience period and the prior two periods if not included in previous filings, for the plans included in the filing.

(d) An estimate of the adjusted earned premium for each month or quarter of the experience period and prior two periods for the plans included in the filing.

(e) Claims data for each month or quarter of the experience period and the prior two periods. Examples of claims data are, incurred claims, capitation payments, utilization data, unit cost data, and staffing data. The specific data elements included in the filing shall be consistent with the carrier's rate-making methodology.

(f) Documentation and justification of any adjustments made to the experience data.

(g) Documentation and justification of the factors and methods used to forecast incurred claims.

(2) An actuarially sound estimate of prudently incurred expenses. Experience data, assumptions, and justifications shall be provided by the carrier as follows:

(a) A breakdown of the carrier's expenses allocated or assigned to the plans included in the filing for the experience period or for the period corresponding to the most recent "annual statement";

(i) Health care service contractors shall provide an expense breakdown at least as detailed as the annual statement schedule "Underwriting and Investment Exhibit, Part 3, Analysis of Expenses" as revised from time to time;

(ii) Health maintenance organizations shall provide an expense breakdown at least as detailed as the "Annual Statement, Report #2: Statement of Revenues, Expenses and Net Worth," for administrative expenses as revised from time to time;

(iii) The allocation and assignment methodology used in (a)(i) or (ii) of this subsection may be based on readily available data and easily applied calculations;

(b) Identification of any experience period expenses that are extraordinary; and

(c) Documentation and justification of the assignment or allocation of expenses to the plans included in the filing; and

(d) Documentation and justification of forecasted changes in expenses.

(3) An actuarially sound provision for contribution to surplus, contingency charges, or risk charges. Assumptions and justifications shall be provided by a carrier as follows:

(a) The methodology, justification, and calculations used to determine the contribution to surplus, contingency charges, or risk charges included in the proposed base rates; and

(b) The carrier's net worth or reserves and unassigned surplus at the beginning of the experience period and at the end of the experience period.

(4) An actuarially sound estimate of forecasted investment earnings on assets related to claim reserves or other similar liabilities. The carrier shall include documentation and justification of forecasted investment earnings identified in dollars, and as a percentage of total premiums and the amount credited to the plans included in the filing.

(5) Adjustment of the base rate. Experience data, assumptions, justifications, and methodology descriptions shall be provided that include:

(a) Justifications for adjustments to the base rate, supported by data if appropriate, attributable to geographic region, age, family size, use of wellness activities, and tenure discounts;

(b) Justifications, supported by data if appropriate, of any other factors or circumstances used to adjust the base rates; and

(c) Description of the methodology used to adjust the base rate to obtain the premium rate for a specific individual or group, which is detailed enough to allow the commissioner to replicate the calculation of premium rates if given the necessary data.

(6) Actuarial certification. Certification by an actuary, as defined by WAC 284-05-060, that the benefits and services to be provided are reasonable in relation to the amount charged.

(7) The requirements of subsections (1) through (6) of this section may be waived or modified upon the finding by the commissioner that a plan contains or involves unique provisions or circumstances and that the requirements represent an extraordinary administrative burden on the carrier. An example of such a situation could include a plan offered by a relatively small carrier, where such plan has limited benefits and is designed to generate an unusually small premium.

RCW 48.19.040

Filing required -- Contents.

(1) *Every insurer or rating organization shall, before using, file with the commissioner every classifications manual, manual of rules and rates, rating plan, rating schedule, minimum rate, class rate, and rating rule, and every modification of any of the foregoing which it proposes.* The insurer need not so file any rate on individually rated risks as described in subdivision (1) of RCW 48.19.030; except that any such specific rate made by a rating organization shall be filed.

(2) *Every such filing shall indicate the type and extent of the coverage contemplated and must be accompanied by sufficient information to permit the commissioner to determine whether it meets the requirements of this chapter.* An insurer or rating organization shall offer in support of any filing:

(a) The experience or judgment of the insurer or rating organization making the filing;

(b) An exhibit detailing the major elements of operating expense for the types of insurance affected by the filing;

(c) An explanation of how investment income has been taken into account in the proposed rates; and

(d) Any other information which the insurer or rating organization deems relevant.

(3) If an insurer has insufficient loss experience to support its proposed rates, it may submit loss experience for similar exposures of other insurers or of a rating organization.

(4) Every such filing shall state its proposed effective date.

(5) A filing made pursuant to this chapter shall be exempt from the provisions of RCW 48.02.120(3). However, the filing and all supporting information accompanying it shall be open to public inspection only after the filing becomes effective.

(6) Where a filing is required no insurer shall make or issue an insurance contract or policy except in accordance with its filing then in effect, except as is provided by RCW 48.19.090.

Commercial Individual Requirements

RCW 48.44.017

Schedule of rates for individual contracts -- Loss ratio -- Remittance of premiums -- Definitions.

(1) The definitions in this subsection apply throughout this section unless the context clearly requires otherwise.

(a) "Claims" means the cost to the health care service contractor of health care services, as defined in RCW 48.43.005, provided to a contract holder or paid to or on behalf of a contract holder in accordance with the terms of a health benefit plan, as defined in RCW 48.43.005. This includes capitation payments or other similar payments made to providers for the purpose of paying for health care services for an enrollee.

(b) "Claims reserves" means: (i) The liability for claims which have been reported but not paid; (ii) the liability for claims which have not been reported but which may reasonably be expected; (iii) active life reserves; and (iv) additional claims reserves whether for a specific liability purpose or not.

(c) "Earned premiums" means premiums, as defined in RCW 48.43.005, plus any rate credits or recoupments less any refunds, for the applicable period, whether received before, during, or after the applicable period.

(d) "Incurred claims expense" means claims paid during the applicable period plus any increase, or less any decrease, in the claims reserves.

(e) *"Loss ratio" means incurred claims expense as a percentage of earned premiums.*

(f) "Reserves" means: (i) Active life reserves; and (ii) additional reserves whether for a specific liability purpose or not.

(2) A health care service contractor shall file, for informational purposes only, a notice of its schedule of rates for its individual contracts with the commissioner prior to use.

(3) A health care service contractor shall file with the notice required under subsection (2) of this section supporting documentation of its method of determining the rates charged. The commissioner may request only the following supporting documentation:

(a) A description of the health care service contractor's rate-making methodology;

(b) An actuarially determined estimate of incurred claims which includes the experience data, assumptions, and justifications of the health care service contractor's projection;

(c) The percentage of premium attributable in aggregate for nonclaims expenses used to determine the adjusted community rates charged; and

(d) *A certification by a member of the American academy of actuaries, or other person approved by the commissioner, that the adjusted community rate charged can be reasonably expected to result in a loss ratio that meets or exceeds the loss ratio standard established in subsection (7) of this section.*

(4) The commissioner may not disapprove or otherwise impede the implementation of the filed rates.

(5) By the last day of May each year any health care service contractor issuing or renewing individual health benefit plans in this state during the preceding calendar year shall file for review by the commissioner supporting documentation of its actual loss ratio for its individual health benefit plans offered or renewed in this state in aggregate for the preceding calendar year. The filing shall include aggregate earned premiums, aggregate incurred claims, and a certification by a member of the American academy of actuaries, or other person approved by the commissioner, that the actual loss ratio has been calculated in accordance with accepted actuarial principles.

(a) At the expiration of a thirty-day period beginning with the date the filing is received by the commissioner, the filing shall be deemed approved unless prior thereto the commissioner contests the calculation of the actual loss ratio.

(b) If the commissioner contests the calculation of the actual loss ratio, the commissioner shall state in writing the grounds for contesting the calculation to the health care service contractor.

(c) Any dispute regarding the calculation of the actual loss ratio shall upon written demand of either the commissioner or the health care service contractor be submitted to hearing under chapters 48.04 and 34.05 RCW.

(6) *If the actual loss ratio for the preceding calendar year is less than the loss ratio standard established in subsection (7) of this section, a remittance is due* and the following shall apply:

(a) The health care service contractor shall calculate a percentage of premium to be remitted to the Washington state health insurance pool by subtracting the actual loss ratio for the preceding year from the loss ratio established in subsection (7) of this section.

(b) The remittance to the Washington state health insurance pool is the percentage calculated in (a) of this subsection, multiplied by the premium earned from each enrollee in the previous calendar year. Interest shall be added to the remittance due at a five percent annual rate calculated from the end of the calendar year for which the remittance is due to the date the remittance is made.

(c) All remittances shall be aggregated and such amounts shall be remitted to the Washington state high risk pool to be used as directed by the pool board of directors.

(d) Any remittance required to be issued under this section shall be issued within thirty days after the actual loss ratio is deemed approved under subsection (5)(a) of this section or the determination by an administrative law judge under subsection (5)(c) of this section.

(7) *The loss ratio applicable to this section shall be seventy-four percent* minus the premium tax rate applicable to the health care service contractor's individual health benefit plans under RCW 48.14.0201.

RCW 48.44.022

Calculation of premiums -- Adjusted community rate -- Definitions.

(1) *Premium rates for health benefit plans for individuals shall be subject to the following provisions:*

(a) The health care service contractor shall develop its rates based on an adjusted community rate and may only vary the adjusted community rate for:

(i) Geographic area;

(ii) Family size;

(iii) Age;

(iv) Tenure discounts; and

(v) Wellness activities.

(b) The adjustment for age in (a)(iii) of this subsection may not use age brackets smaller than five-year increments which shall begin with age twenty and end with age sixty-five. Individuals under the age of twenty shall be treated as those age twenty.

(c) The health care service contractor shall be permitted to develop separate rates for individuals age sixty-five or older for coverage for which Medicare is the primary payer and coverage for which Medicare is not the primary payer. Both rates shall be subject to the requirements of this subsection.

(d) The permitted rates for any age group shall be no more than four hundred twenty-five percent of the lowest rate for all age groups on January 1, 1996, four hundred percent on January 1, 1997, and three hundred seventy-five percent on January 1, 2000, and thereafter.

(e) A discount for wellness activities shall be permitted to reflect actuarially justified differences in utilization or cost attributed to such programs not to exceed twenty percent.

(f) The rate charged for a health benefit plan offered under this section may not be adjusted more frequently than annually except that the premium may be changed to reflect:

(i) Changes to the family composition;

(ii) Changes to the health benefit plan requested by the individual; or

(iii) Changes in government requirements affecting the health benefit plan.

(g) *For the purposes of this section, a health benefit plan that contains a restricted network provision shall not be considered similar coverage to a health benefit plan that does not contain such a provision, provided that the restrictions of benefits to network providers result in substantial differences in claims costs.* This subsection does not restrict or enhance the portability of benefits as provided in RCW 48.43.015.

(h) A tenure discount for continuous enrollment in the health plan of two years or more may be offered, not to exceed ten percent.

(2) *Adjusted community rates established under this section shall pool the medical experience of all individuals purchasing coverage*, and shall not be required to be pooled with the medical experience of health benefit plans offered to small employers under RCW 48.44.023.

(3) As used in this section and RCW 48.44.023 "health benefit plan," "small employer," "adjusted community rates," and "wellness activities" mean the same as defined in RCW 48.43.005.

WAC 284-43-915

Demonstration that benefits provided are not reasonable in relation to the amount charged for a contract per RCW 48.44.020 (2)(d) and 48.46.060 (3)(d). In addition to the requirements of RCW 48.44.022, 48.44.023, 48.46.064, and 48.46.066, where applicable:

(1) For individual and small group plans, benefits shall be found not to be unreasonable in relation to the amount charged if one or more of the following is true:

(a) The requested increase in the community rate is zero percent or less and the anticipated loss ratio is seventy percent or more; or

(b) The anticipated loss ratio is eighty percent or more and the requested increase in the community rate is not more than the applicable rate in the following table.

CPI*	Maximum Rate Increase
7% or less	CPI*+3%
7% to 10%	10%
10% or more	CPI*

* CPI refers to the rate of increase in the medical care component of the consumer price index for all urban consumers.

(2) For group plans other than small group plans, benefits shall be found not to be unreasonable in relation to amount charged if the anticipated loss ratio is eighty percent or more.

(3) If the conditions of subsection (1) or (2) of this section are not met, benefits shall be found not to be unreasonable if the projected earned premium for the rate renewal period is equal to the following:

(a) An actuarially sound estimate of incurred claims associated with the filing for the rate renewal period, where the actuarial estimate of claims shall recognize, as applicable, the savings and costs associated with managed care provisions of the plans included in the filing; plus

(b) An actuarially sound estimate of prudently incurred expenses associated with the plans included in the filing for the rate renewal period, where the estimate shall be based on an equitable and consistent expense allocation or assignment methodology; plus

(c) An actuarially sound provision for contribution to surplus, contingency charges, or risk charges, where the justification shall recognize the carrier's investment earnings on assets other than those related to claim reserves or other similar liabilities; minus

(d) An actuarially sound estimate of the forecasted investment earnings on assets related to claim reserves or other similar liabilities for the plans included in the filing for the rate renewal period.

(4) The contribution to surplus, contingency charges, or risk charges in subsection (3)(c) of this section, shall not be required to be less than zero.

(5) For the purposes of this section, the rate of increase in the medical care component of the consumer price index for all urban consumers shall be measured by comparing the index for the month immediately preceding the month in which the filing is submitted to the index for the corresponding calendar month for the prior year.

Commercial Small Group Requirements

RCW 48.44.023

Mandatory offering providing basic health plan benefits for employers with fewer than twenty-five employees -- Exemption from statutory requirements -- Premium rates -- Requirements for providing coverage for small employers.

(1)(a) A health care services contractor offering any health benefit plan to a small employer shall offer and actively market to the small employer a health benefit plan providing benefits identical to the schedule of covered health services that are required to be delivered to an individual enrolled in the basic health plan. Nothing in this subsection shall preclude a contractor from offering, or a small employer from purchasing, other health benefit plans that may have more or less comprehensive benefits than the basic health plan, provided such plans are in accordance with this chapter. A contractor offering a health benefit plan that does not include benefits in the basic health plan shall clearly disclose these differences to the small employer in a brochure approved by the commissioner.

(b) A health benefit plan shall provide coverage for hospital expenses and services rendered by a physician licensed under chapter 18.57 or 18.71 RCW but is not subject to the requirements of RCW 48.44.225, 48.44.240, 48.44.245, 48.44.290, 48.44.300, 48.44.310, 48.44.320, 48.44.325, 48.44.330, 48.44.335, 48.44.340, 48.44.344, 48.44.360, 48.44.400, 48.44.440, 48.44.450, and 48.44.460 if: (i) The health benefit plan is the mandatory offering under (a) of this subsection that provides benefits identical to the basic health plan, to the extent these requirements differ from the basic health plan; or (ii) the health benefit plan is offered to employers with not more than twenty-five employees.

(2) Nothing in this section shall prohibit a health care service contractor from offering, or a purchaser from seeking, benefits in excess of the basic health plan services. All forms, policies, and contracts shall be submitted for approval to the commissioner, and the rates of any plan offered under this section shall be reasonable in relation to the benefits thereto.

(3) *Premium rates for health benefit plans for small employers as defined in this section shall be subject to the following provisions:*

(a) The contractor shall develop its rates based on an adjusted community rate and may only vary the adjusted community rate for:

(i) Geographic area;

(ii) Family size;

(iii) Age; and

(iv) Wellness activities.

(b) The adjustment for age in (a)(iii) of this subsection may not use age brackets smaller than five-year increments, which shall begin with age twenty and end with age sixty-five. Employees under the age of twenty shall be treated as those age twenty.

(c) The contractor shall be permitted to develop separate rates for individuals age sixty-five or older for coverage for which Medicare is the primary payer and coverage for which Medicare is not the primary payer. Both rates shall be subject to the requirements of this subsection (3).

(d) The permitted rates for any age group shall be no more than four hundred twenty-five percent of the lowest rate for all age groups on January 1, 1996, four hundred percent on January 1, 1997, and three hundred seventy-five percent on January 1, 2000, and thereafter.

(e) A discount for wellness activities shall be permitted to reflect actuarially justified differences in utilization or cost attributed to such programs not to exceed twenty percent.

(f) The rate charged for a health benefit plan offered under this section may not be adjusted more frequently than annually except that the premium may be changed to reflect:

(i) Changes to the enrollment of the small employer;

(ii) Changes to the family composition of the employee;

(iii) Changes to the health benefit plan requested by the small employer; or

(iv) Changes in government requirements affecting the health benefit plan.

(g) Rating factors shall produce premiums for identical groups that differ only by the amounts attributable to plan design, with the exception of discounts for health improvement programs.

(h) *For the purposes of this section, a health benefit plan that contains a restricted network provision shall not be considered similar coverage to a health benefit plan that does not contain such a provision, provided that the restrictions of benefits to network providers result in substantial differences in claims costs.* This subsection does not restrict or enhance the portability of benefits as provided in RCW 48.43.015.

(i) *Adjusted community rates established under this section shall pool the medical experience of all groups purchasing coverage.*

(4) The health benefit plans authorized by this section that are lower than the required offering shall not supplant or supersede any existing policy for the benefit of employees in this state. Nothing in this section shall restrict the right of employees to collectively bargain for insurance providing benefits in excess of those provided herein.

(5)(a) Except as provided in this subsection, requirements used by a contractor in determining whether to provide coverage to a small employer shall be applied uniformly among all small employers applying for coverage or receiving coverage from the carrier.

(b) A contractor shall not require a minimum participation level greater than:

(i) One hundred percent of eligible employees working for groups with three or less employees; and

(ii) Seventy-five percent of eligible employees working for groups with more than three employees.

(c) In applying minimum participation requirements with respect to a small employer, a small employer shall not consider employees or dependents who have similar existing coverage in determining whether the applicable percentage of participation is met.

(d) A contractor may not increase any requirement for minimum employee participation or modify any requirement for minimum employer contribution applicable to a small employer at any time after the small employer has been accepted for coverage.

(6) A contractor must offer coverage to all eligible employees of a small employer and their dependents. A contractor may not offer coverage to only certain individuals or dependents in a small employer group or to only part of the group. A contractor may not modify a health plan with respect to a small employer or any eligible employee or dependent, through riders, endorsements or otherwise, to restrict or exclude coverage or benefits for specific diseases, medical conditions, or services otherwise covered by the plan.

Technical Advisories

TAA 2000-07

4. Question: What adjustments for geographic factors are allowed?
Answer: RCW 48.44.022(2), 48.44.023(3)(i), 48.46.064(2), 48.46.066(3)(i), 48.20.028(2), and 48.21.045(3)(i) state that adjusted community rates shall pool the medical experience of all individuals or groups purchasing coverage. *The geographic factors must be based on credible data or a large study. A carrier must not base its geographic factors on its own experience by geographic area; that would violate the pooling requirements of community rating.*